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First Principles Review of the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF

The AMA believes that the Medical Indemnity system is working well, providing ongoing stability and affordability. This broader review offers the opportunity to reflect upon its success and consider improvements to ensure ongoing affordable indemnity insurance.

Any review of the schemes must have as a key outcome the long-term financial sustainability of the market for medical indemnity insurance and, through this, provide certainty to medical practitioners as to the adequacy and availability of ongoing cover. However, the key consideration in this review must be that these schemes are really a system to support compensation for patients, and that affordable indemnity insurance is directly related to affordable care.

In Australia, it is a mandatory requirement for registered healthcare practitioners to hold appropriate medical indemnity insurance cover for healthcare practice. Medical indemnity is a form of professional indemnity insurance cover defined by Australian legislation – the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*.

Medical indemnity refers to the system for redress of adverse health care outcomes arising from medical treatment in which standards of care are breached. It provides a framework to be followed for health care professionals and their patients in the event of a breach, or perceived breach of a given standard of care, and a system for compensation of injured patients. While Australia's health system is very safe, there are occasional issues, and sometimes patients may be harmed in the process of receiving medical care. Roughly 2,000 claims of negligence might be expected each year in relation to private medical practice in Australia. However, there can be substantial variation from one year to the next¹.

Since 2003, the Commonwealth has subsidised indemnity insurance premiums for medical practitioners in Australia and provided financial assistance to indemnity providers and medical practitioners for high-cost claims. This followed the collapse of HIH Insurance in 2001 and United Medical Insurance in 2002. The initiatives were a response to a market failure and

¹ http://www.aga.gov.au/publications/runoff_cover_2011/medical_indemnity/02_background.asp

intended to make the indemnity market more sustainable, giving doctors the certainty they need to continue practicing and making medical indemnity cover more affordable.

The medical indemnity crisis was not unique to Australia. Many countries have experienced difficulties at various times since the early 2000's with escalating claims and costs, which hampered confidence in the healthcare system². The success of the Australian schemes should be commended, particularly in light of the significant turbulence other countries are experiencing with their indemnity schemes.

At the pinnacle of this crisis, many practitioners faced uncertainty about the future of their practice, and/or insurance premiums that would have made their practice unviable.

Patients may have been faced with uncertainty that, in the rare case of an adverse event, there may no longer be financial support for their ongoing care.

It is no overstatement to say the lack of stability was crippling the provision of healthcare – even threatening the ability of doctors to turn up to work.

The AMA condemned the move in the 2016 Mid-Year Economic and Fiscal Outlook to cut funding from schemes that have provided much needed stability to the sector, particularly doing so ahead of this review taking place.

Context of the schemes

Until 2001, most medical indemnity insurance cover was provided by medical defence organisations—which differed from general insurance providers as cover was provided on a discretionary basis. The 2001 financial collapse of HIH Insurance Limited—a major reinsurer of United Medical Protection Limited/Australasian Medical Insurance Limited (UMP/AMIL), Australia's largest medical defence organisation—was a critical event for the medical indemnity insurance industry.

It was also a catalyst for increased government intervention in the medical indemnity insurance industry, including substantial legal, regulatory and funding reform. UMP/AMIL was placed into provisional liquidation in May 2002 '...which resulted in a potential lack of indemnity cover for many doctors' in Australia'.

At the same time, medical practitioners experienced significant increases in the insurance premiums being levied by all medical indemnity providers. In extreme cases, some medical practitioners were paying indemnity insurance premiums representing over a third of their incomes while others left the profession or ceased certain high-risk procedures like obstetrics³.

² https://www.actuaries.asn.au/Library/ACS09_Paper_Toh%20et%20al..pdf

³ ANAO Report No.20 2016–17 The Management, Administration and Monitoring of the Indemnity Insurance Fund, p 15

For the Australian Government, these events created two broad, inter-related and complex policy issues that needed immediate attention while recognising that any longer-term solution would require a whole-of-government approach⁴.

The issue of instable medical indemnity insurance was truly global, stretching from America to Europe to Asia. For example:

- In the United States, premiums in several states increased at an annual rate of 30% per annum from 2000. By 2001, obstetricians in Florida were required to pay between US\$143,000 and US\$203,000. In 2002 the St Paul group of companies exited the US market, followed by several other regional insurers. Together, these insurers accounted for approximately 14% of the US market.
- In France, a law was enacted in 2002 introducing a mandatory requirement for insurers to cover medical liability risk without a specified ceiling. In particular, it gave powers to the “Bureau Central de Tarification” to assess and set a rate for an insurer in cases where a health care provider has twice been denied coverage. This led to a massive withdrawal of insurers and a rapid increase in premiums of up to 600%.
- In Hong Kong, the average premium for private orthopaedic practice rose from \$3,237 in 2002 to \$21,400 in 2007⁵.

Context of the review

This review provides an opportunity to reflect and consider whether the schemes are achieving the dual policy objectives of providing long-term financial sustainability of the medical indemnity insurance market, whilst also ensuring that indemnity insurance remains affordable.

Average medical indemnity premiums increased by 221 per cent between 1995 and 2005 (at an average rate of 13 per cent per annum). The largest annual increase was in 2002, when the average premium rose nearly 50 per cent⁶.

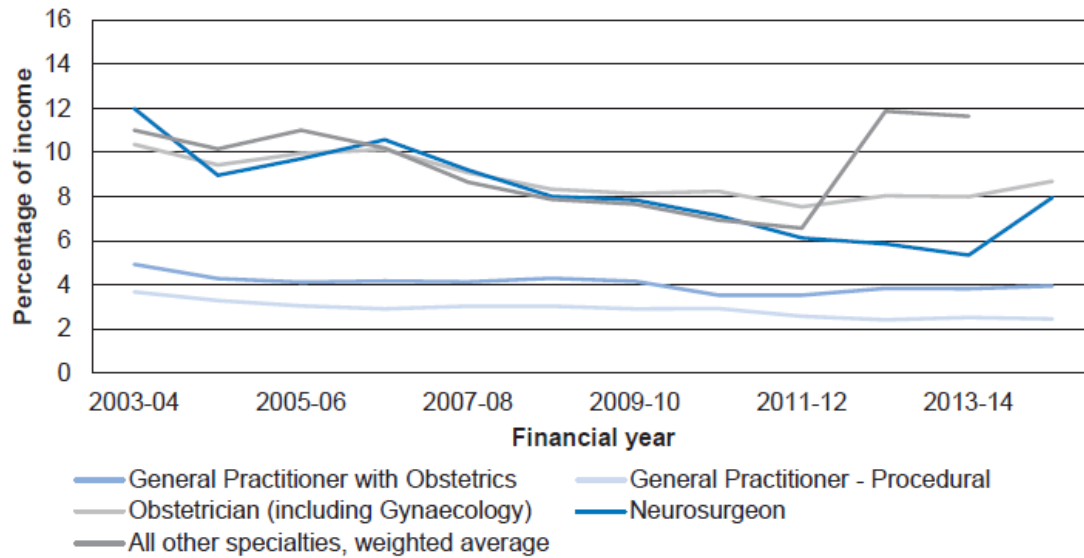
However, as can be seen by the graph below, the weighted average for premiums for all other specialties is a higher proportion of income than it was when the IIF commenced in 2003. Of note is also a sharp increase in the premiums for neurosurgeons commencing in 2013-14⁷.

⁴ ANAO Report No.20 2016–17 The Management, Administration and Monitoring of the Indemnity Insurance Fund, p 15

⁵ https://www.actuaries.asn.au/Library/ACS09_Paper_Toh%20et%20al..pdf

⁶ Medical Indemnity Industry Association of Australia. Medical indemnity report: an analysis of premium and claim trends in Australia from 1995 to 2005, 21 August 2006. Prepared by Insurance Statistics Australia Limited

⁷ ANAO Report No.20 2016–17 The Management, Administration and Monitoring of the Indemnity Insurance Fund, p 46



The discussion paper highlights changes to the environment that needs to be considered. The first is the amount of legal certainty and amount of claims. It is noted in the paper that the tort law reforms of the early 2000s have had the desired effect of limiting the extent of damages payable by insurers. This, combined with a greater understanding of the nature of claims (size and frequency) and lesser claims overall, has contributed to the stability of the sector.

Potential for significant changes to the claims pattern

Medical indemnity insurance is different to many other types of insurance. Most substantive medical malpractice claims can take several years (potentially more than five years) to settle from occurrence of the injury. Claims involving obstetrics can literally take decades to emerge, let alone be resolved in a short time frame. Each claim involves several stages from discovery of the malpractice, to filing of the claim, establishing the rights to compensation and financial responsibilities, agreement to settle or go to trial (in tort based jurisdictions), through to actual payment of the claim. This in itself, makes the prediction of potential losses and the setting of appropriate premium rates a challenging task, where the likelihood of claims is only somewhat predictable based upon previous claim history⁸.

However, there is a major unknown on the horizon. There remains the ability for the CEO of the National Disability Insurance Scheme to require a participant or a prospective participant to take action to claim or obtain compensation. The NDIS is not fully implemented and the compensation and budgetary outcomes are not fully known at present. The Productivity Commission, in its 2017 review of the NDIS costs, noted that

⁸ https://www.actuaries.asn.au/Library/ACS09_Paper_Toh%20et%20al..pdf

“for the scheme to achieve its objectives, the NDIA must find a better balance between participant intake, the quality of plans, participant outcomes, and financial sustainability”⁹.

It is prudent for MDO’s to retain funds to cover potential outlays under the NDIS.

Compounding the unknown amount of potential claims under the NDIS, is the partial implementation of the NIIS. The states have not pursued the medical and general accident streams and it is the AMA’s position, that whilst ideal, the implementation of a NIIS for catastrophic medical accidents is extremely difficult. However, this means that some people who would be expected to have their needs met through NIIS will instead need to have them met by the NDIS.

The Productivity Commission has noted that, the states and territories should bear the consequential NDIS costs if the NIIS remains only partially implemented. However, in the absence of an NIIS, the states may seek that the CEO request the participants to seek compensation through the NDIS.

It would therefore also be prudent for the MDOs to ensure there is sufficient capital base to cover these claims should they eventuate.

With these potential changes to claiming patterns, the AMA believes that it is important that the national database on medical indemnity claims be maintained. The Public Sector Medical Indemnity National Collection (MINC PS) was established to collate information on the number, nature and costs of public sector medical indemnity claims. Since 2004 medical indemnity insurers have provided the Australian Government with information on private sector medical indemnity claims¹⁰. This information is important for our understanding of medical compensation trends in Australia.

New entrants to the market

There are new entrants to the medical indemnity insurance market.

Some insurers are required to offer what is known as Universal Cover for practitioners. These insurers are known as the ‘Insurer of last resort’ for the state that they provide Universal Cover. This effectively means that any practitioner can obtain cover.

Some of the newer entrants to the insurance market, however, have not contracted with the Federal Government under the Premium Support Scheme and are also exempt from the Universal Cover arrangements.

The Universal Cover arrangements are important protection for patients. These provisions ensure that practitioners can obtain insurance and this lowers the risk to patients of practitioners being unable to meet the cost of a successful claim.

From an AMA perspective, there is a strong belief in the importance of universal cover, and that all indemnity insurers should be required to provide it. It is important that the operation of the IFF is fair and equitable and does not encourage risk minimisation strategies that may leave some practitioners without insurance. The AMA does not support a situation where an insurer,

⁹ Productivity Commission 2017 *National Disability Insurance Scheme (NDIS) Costs*, Position Paper, Canberra, p2.

¹⁰ <http://www.aihw.gov.au/medical-indemnity/>

rather than a regulator, decides who can effectively practice in the medical profession and would object strongly to any policy decisions that could give rise to an insurer being able to 'price' a practitioner out of the market.

Using Medical Defence Organisation Data for performance assessment

It is clear that there is an appetite in some jurisdictions for looking at mechanisms to reveal potentially poorly performing doctors. The AMA is concerned about reports that the COAG Health Council is considering altering the definition of a 'notifiable event' under the National Law, requiring medical practitioners to advise the Australian Health Practitioner Regulation Agency (AHPRA) of confidential legal settlements and the receipt of a civil claim.

The AMA does not support poorly performing practitioners. However, a civil claims settlement, and poor medical practice are not necessarily the same thing. The AMA does not support Medical Defence Organisation data being used as a de-facto identification tool for poor performance. There is no evidence that claims data would accurately identify practitioners whose performance is substandard.

Premium Support Scheme

The AMA notes the current trend for decreasing demand for the Premium Support Scheme. However, this scheme provides assistance based upon ability to pay, which is a key objective of the IIF. The PSS is the first line of defence against practitioners against high future claims and resulting large premium increases. This scheme is potentially supporting rural practitioners or certain practitioners who offer services to less mobile or less affluent populations.

Table 2.2: Participation levels and impact of the Premium Support Scheme, 2013–14^(a)

Specialty	Doctors in PSS	PSS cost per doctor		Premium set by insurers, prior to PSS subsidy		Premium, including PSS subsidy	
		\$ 000	Private income \$ 000	\$ 000	Per cent of income ^(b)	\$ 000	Per cent of income
GP with obstetrics	177	8	383	15	4	7	2
GP procedural	531	3	309	8	3	5	2
Obstetrician ^(c)	293	15	695	56	8	41	6
Neurosurgeons	45	11	878	47	5	36	4
Other specialities ^(d)	551	2	85	10	12	7	9

Note a: Data for 2013–14 used, as income data for 2014–15 was incomplete.

Note b: Significant proportions of these speciality groups continue to receive PSS subsidies due to MISS grandfathering arrangements.

Note c: Includes gynaecology.

Note d: Weighted average across all other specialities.

Source: ANAO analysis on Human Services' PSS data.

It would appear from the ANAO data¹¹ that the scheme is providing considerable support to professions who have higher premiums, in particular those who practice obstetrics. Private obstetrics in Australia is in decline as evidenced by the drop in pregnancy management items¹².

		State								Total
		NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
		Services	Services	Services	Services	Services	Services	Services	Services	
16590	2012/2013	33,454	26,852	18,759	7,064	14,958	2,105	1,386	787	105,365
	2013/2014	32,053	24,126	18,688	6,855	15,985	2,038	1,314	697	101,756
	2014/2015	31,331	22,644	16,454	6,639	15,792	1,896	1,232	638	96,626
	2015/2016	31,579	22,343	16,198	6,322	15,534	1,645	1,295	557	95,473
	2016/2017	30,657	21,698	14,898	5,992	14,226	1,484	1,227	585	90,767
	Total	159,074	117,663	84,997	32,872	76,495	9,168	6,454	3,264	489,987

Increasing the patients out-of-pocket costs through a reduction in the support provided by the PSS will increase the difficulties patients face when accessing private obstetrics. After years of an MBS freeze, inadequate indexation and an ongoing environment of cost cutting, it must be recognized that the profession can no longer absorb these cuts.

Without detailed knowledge of why the indemnity insurance forms such a high proportion of income, it would be unwise to make change to this support scheme. The removal of this support may mean that some practitioners are forced to either charge higher fees, or cease practicing in rural areas. The removal of this support could directly negatively impact access to care.

Further information on who uses the PSS is needed to inform consideration of its value.

High Cost Claims Scheme

The amount that the Commonwealth contributes to the High Cost Claims Scheme (HCCS) is set to diminish as a result of the Mid-year Economic and Fiscal Outlook changes in 2016. The HCCS pays 50% of the cost of claims over \$300,000, with the claim threshold increasing to \$500,000 in July 2018. Avant, the largest insurer, noted when the claim threshold rise was announced, that the increase from \$300,000 to \$500,000 would lead to an estimated average increase to doctors' premiums of 5%. Medical practitioners cannot absorb such large increases in premiums and these costs will, in turn, have to be passed onto patients.

Given the uncertainty around claims coming from the NDIS, and the potentially large sums of money that may be awarded, it would seem prudent to leave the threshold at the new level and evaluate the schemes effectiveness once the combined impact of the NDIS and the altered threshold is known.

This scheme stabilized the market by minimizing the impact of large claims upon insurers. To this end, it has been particularly successful at meeting its policy objective.

¹¹ ANAO Report No.20 2016–17 The Management, Administration and Monitoring of the Indemnity Insurance Fund, p 34

¹² MBS item 16590 from Medical Item Reports: Department of Human Services

Exceptional Claims Scheme

The exceptional claims scheme caps the size of the claims for which insurers will be responsible. Under this scheme the Commonwealth pays the amount of any claims that are in excess of the threshold of \$20 million.

This scheme has been very successful at providing certainty for insurers. It provides a limit on the potential size of claim that insurers must factor into their capital budgets. It would appear to also put a price ceiling on claims as this scheme has not been used to date.

Given that there is a very real risk of claims of this size being awarded in the future the scheme should remain.

Run-off Cover Scheme

Under the Run-off Cover Scheme (ROCS) the Federal Government provides funding for claims against practitioners who have left the private medical workforce. Run-off cover is provided for doctors who retire and are aged 65, and this is funded by a levy applied to all medical indemnity insurance premiums each year. Without this scheme, practitioners would need to purchase medical indemnity insurance from their retirement income. This would not be feasible or enforceable and would have an undermining effect on Government's efforts with regard to the medical workforce.

This scheme provides an assurance to patients that they will be covered should a claim be made against a practitioner after they have ceased working.

As greater amounts of practitioners retire, the need to ensure the ROCS is operating effectively will increase. The ROCS is required to be maintained to provide coverage for practitioners and their patients.

Incurred but not Reported Claims Scheme

A scheme to support patients who may need to make a claim for this small group of unfunded incurred but not reported liabilities of the former UMP is required until there are no further cases left. Since the IBNR scheme will naturally terminate over the next 10 years, the AMA does not see any advantages in making substantial changes to the scheme at this point in time.

Public Hospital indemnity cover

Whilst outside the scope of the review, problems encountered by locums in state public hospitals were raised with the AMA. It would appear that some states are no longer providing indemnity insurance for locum workers, instead they are demanding that the locums self-fund their insurance. Noting the Commonwealth's objective to ensure that we have an adequate medical workforce and coverage nationally, maintaining affordable and stability indemnity insurance for locum workers is critical.

Summary

The position paper notes the affordability of premiums has improved, which demonstrates the success of the policies. The AMA notes that premiums have become more affordable for some

cohorts, but the support needs to remain for the sector as affordability improvements have not been universal.

The affordability of premiums, in a time where the Medicare Benefit has been frozen for around 4 years and other costs of business have been increasing, is directly linked to providing affordable care, which is an issue the profession is focused on right now.

The IFF scheme has provided a system for redress for patients in the rare event of adverse health care outcomes arising from medical treatment. The Australian scheme, which has operated effectively for the past 15 years, is a success.

Successive governments should be applauded for having worked with the AMA and the profession to develop these schemes that provide stability and certainty. The value of which, in the opinion of the AMA, is far beyond their moderate cost.

Now is the time to reaffirm their importance, to consider their ongoing need, but not to use the review and a mechanism for an ill-conceived savings exercise. The risks and potential consequences for patients and practitioners are far too great.